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Board of Registration in Medicine

$495 ck'd 2/26/02

Application #: 7980
Date Approved: 2/26/02

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, Third Floor, Boston, Massachusetts 02111 - www.massmedboard.org

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

1. Name: (Last) BADGAIYAN (First) RAJENDRA (MI) D
2. Mailing Address: 122-A, Sycamore St. Telephone Number: 617-623-1140
   City: Somerville State: MA Zip: 02145
3. Name of Training Hospital: BROCKTON VA MEDICAL CENTER
4. Current Limited License Number: 7980
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) N/A

SECTION B: To be completed by program director.

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☑ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: GRACE J. MUSHRUSH, M.D. Date: 2/14/02

Signature of Program Director: Grace J Mushrush MD Telephone: 508-583-4500 x2457

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that RAJENDRA BADGAIYAN (Name of Applicant) has been appointed

to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY IV

Hospital Name: Harvard So. Shore Psychiatry Residency Training Program at BROCKTON VA MEDICAL CENTER Specialty: PSYCHIATRY

Beginning Date: 8/31/98 Anticipated Completion Date of Training: 10/18/2003

Is the program accredited by the ACGME: ☑ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Grace J. Mushrush, M.D., Asst. Chief of Psychiatry for Education & Director, HSSPRTP (Print Name) Telephone: 508-583-4500 x2457

Designated Official's Signature: Grace J Mushrush MD (Title) Date: 2/14/02

NAME: Rajendra D. Badgaiyan

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

THESE QUESTIONS APPLY ONLY SINCE YOUR LAST RENEWAL	YES	NO
16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?	☐	☒
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?	☐	☒
18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?	☐	☒
19. Have you voluntarily surrendered a license to practice medicine or any healing art?	☐	☒
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).	☐	☒
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).	☐	☒
22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?	☐	☒
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?	☐	☒
24. Have you voluntarily relinquished medical staff membership?	☐	☒
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?	☐	☒
26. Have you been charged with any criminal offense, other than a minor traffic offense?	☐	☒
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?	☐	☒
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?	☐	☒
29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?	☐	☒

COMMONWEALTH OF MASSACHUSETTS–BOARD OF REGISTRATION IN MEDICINE
10 WEST STREET, BOSTON, MA 02111 - (617) 727-3086

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Rajendra Dhar Badgaiyan
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency, (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other documents, concerning my professional qualifications and competency, ethics, character, and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents and records be sent directly to:

Board of Registration in Medicine
10 West Street, Boston, MA 02111
Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed enveloped and that none of the seals have been broken.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

RBadgaiyan
Applicant's Signature

2/6/02
Date of Signature

BADGAIYAN, RAJENDRA, D.
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

07/14/1955
Applicant's Date of Birth (month/day/year)